

Subscriber name: \_\_\_\_\_ Student: \_\_\_\_\_  
Address 1: \_\_\_\_\_  
Address 2: \_\_\_\_\_ Harvard Pilgrim ID#: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

## FULL-TIME STUDENT VERIFICATION AFFIDAVIT

Note: This form only applies to dependents age 19 and older.

I hereby certify that _____		
(Name of student dependent)	(Social Security Number)	____/____/____ (Date of Birth)
is either:		
(please check one)	<input checked="" type="checkbox"/> <b>A FULL-TIME student (age 19 and older and unmarried) at</b>	
_____		
(Educational institution: high school, college, university, other)		
_____		_____
(City/Town)		(State)
for the semester ____/____/____ to ____/____/____		or school year _____
Expected Graduation Date: ____/____		
<b>or</b>		
<input checked="" type="checkbox"/> <b>Is no longer a full-time student</b>		

I hereby certify that the information provided above is correct. I understand that I am obligated to inform Harvard Pilgrim Health Care, Inc. ("HPHC"), including Harvard Pilgrim Health Care of New England ("HPHC-NE") and HPHC Insurance Company, of any change in the noted dependent's student status. To ensure accuracy, I acknowledge and agree that HPHC, including HPHC-NE and HPHC Insurance Company, may investigate the status of the noted dependent during the period in which the dependent is claiming full-time student standing. I understand that any misrepresentation in the information I have provided above will permit HPHC, including HPHC-NE and HPHC Insurance Company, to terminate the dependent's membership and seek any other legal remedies available to HPHC, including HPHC-NE and HPHC Insurance Company.

I understand that the dependent's coverage may not be effective until a signed affidavit is returned to HPHC, including HPHC-NE and HPHC Insurance Company.

Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature) Subscriber/Spouse

\_\_\_\_\_  
(Relation to student dependent)

Please note: This affidavit will only be accepted if signed by the subscriber, parent, stepparent or guardian.  
Fold and return in enclosed envelope or fax to:

Harvard Pilgrim Health Care  
Student Verification Processing  
1600 Crown Colony  
Quincy, MA 02169-9978

FAX: 617-509-1539  
(If faxing, please **do not** mail form.)



Harvard Pilgrim  
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This information refers to plans offered by Harvard Pilgrim Health Care and its affiliates,  
Harvard Pilgrim Health Care of New England and HPHC Insurance Company.